Transferring Risk – the Road to Health Care Value

26th Annual
Rural Health Care Leadership Conference
February 10–13, 2013 • Phoenix, AZ
Pointe Hilton Tapatio Cliffs Resort

A. Clinton MacKinney, MD, MS
Deputy Director and Assistant Professor
RUPRI Center for Rural Health Policy Analysis
University of Iowa | College of Public Health
clint-mackinney@uiowa.edu
Agenda

- Health care **value**
- Health care **risk**
- Transferring risk from payers to hospitals and physicians
  - Fundamental to health care reform
  - Accountable care organizations (for example)
- Strategies for success
  - Ideas for innovative rural hospital leaders
Value – IOM Six Aims

Health care should be:

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

The Triple Aim

- Population Health
- Experience of Care
- Per Capita Cost

Clint MacKinney, MD, MS

CMS
Centers for Medicare & Medicaid Services

rupri
Rural Policy Research Institute

The University of Iowa
Value Equation

Value = Quality + Experience

Cost

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

“Triple Aim”
- Better care
- Better health
- Lower cost
Mortality Amenable to Health Care by State
Deaths* per 100,000 Population

2004–05

Quartile (range)

- Top (63.9–76.8) Best: MN
- Second (77.2–89.9)
- Third (90.7–107.5)
- Bottom (108.0–158.3) Worst: DC

* Age-standardized deaths before age 75 from select causes; includes ischemic heart disease.
** Excludes District of Columbia.
DATA: Analysis of 2001–02 and 2004–05 CDC Multiple Cause-of-Death data files using Nolte and McKee methodology, BMJ 2003
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Clint MacKinney, MD, MS
Patients who reported YES, they would definitely recommend the hospital.

**Why is this important?**

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST GABRIELS HOSPITAL</td>
<td>74.0%</td>
</tr>
<tr>
<td>ST CLOUD</td>
<td>81.0%</td>
</tr>
<tr>
<td>Average for all Reporting Hospitals in Minnesota</td>
<td>72.0%</td>
</tr>
<tr>
<td>Average for all Reporting Hospitals in The United...</td>
<td>70.0%</td>
</tr>
</tbody>
</table>


Clint MacKinney, MD, MS
Medicare Spending Per Enrollee

Source: Kaiser Family Foundation. 2009 Data

Clint MacKinney, MD, MS
Sources: K. Baicker and A. Chandra, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care," Health Affairs Web Exclusive (April 7, 2004).
Unacceptable Healthcare Value

- **Quality** suboptimal
  - Deficient when compared internationally
  - Wide geographic variation

- **Cost** unsustainable
  - Growth in excess of GDP growth
  - Highest cost in the world

- **Waste** intolerable (20%)*
  - Care delivery, care coordination, overtreatment, administration, pricing failures, fraud and abuse

- **Our volume-based payment system is a significant problem**

“Successful” physicians and hospitals seek to maximize:
- Office visits per day
- Average daily inpatient census
- Admission percent from the ER
- Profitability

Is this how you would identify and reward a great physician or a world-class hospital?

No, but what to do?
The Value Conundrum

You can always count on Americans to do the right thing – after they’ve tried everything else.

- Fee-for-service
- Capitation
- Market
- Single payer
- Self-police

- Regardless of what we try, we tend to “follow the money”
How we deliver care is predicated on how we get paid for care.

Health care reform is changing both.

Fundamentally, reform involves a transfer of risk from payers to providers.
Risk Assessment is Ubiquitous

- Risk is present when an outcome is uncertain or unpredictable

- Types of health care risk
  - Random
  - Insurance
  - Political
  - Medical Care

- Where/how can hospitals
  - Influence or control risk
  - Reduce risk of harm
  - Optimize risk of benefit
Rural Risk?
- Normal variation
- Rolling the dice
- Roulette v. poker
- **No** control, but important to recognize
Insurance Risk

- Insurance risks
  - Demographic change
  - Technological innovations
  - Prior health status
  - Cost inflation
- Cost is the actuarial metric
- Minimal control, but predictable
Political Risk

- Rules, regulations, and legislation
- Profound impact on health care delivery and finance
- Modest control, often via advocacy avenues

American Hospital Association
Medical Care Risk

- Medical care variation
  - Diagnostic accuracy
  - Care plan implementation
  - Guideline use compliance
  - Pharmaceutical choice
  - Procedural skill
  - Efficient resource use

- How our choices influence health care value

- Greatest control, how we deliver care
The Risk of Inertia

Because we’ve ALWAYS done it that way!
The Risk of Doing Nothing

"We've considered every potential risk except the risks of avoiding all risks."

Clint MacKinney, MD, MS
Payment Risk Continuum

High Payer Risk
- Cost-Based
  - Charge-Based
    - Per Diem
  - Case Rate

High Provider Risk
- Capitation
  - Shared Risk
    - Bundled
  - ACOs
A coordinated network of providers with shared responsibility for providing high quality and low cost care to their patients.*

Couples risk-based provider payment with health care delivery system reform

Accepts performance risk for quality and cost

- Rural ACOs in 23 states
- 45 ACOs in rural counties
- 25-31 million patients receive care through an ACO
- ~10% of the population
- Remarkably quick growth for a new and complex form of payment and care delivery

Source: RUPRI Center for Rural Health Policy Analysis, 2013.
New World Realities

- **Risk transfer to providers**
  - Higher quality at lower cost
  - Doing what’s needed, not more

- **New business models**
  - More primary care, less inpatient
  - Rewarding value, not just volume

- **The devil is in the transition**
  - One foot on the dock and one in the boat
  - It’ll be competitive – winners and losers
Tool Box for Delivering Value

Strategies
- Cultural considerations
- System thinking
- Performance improvement
- Variation reduction
- Medical homes
- Medical staff development
- Collaborations
- What we can do now
Culture

- Culture is the residue of success.*
- An environment of behaviors and beliefs
- **What we do becomes what we believe.**

* Source: Edgar Schein, 1999
Nutting et al – small primary care practices are:

- Physician-centric
- A hindrance to meaningful communication between physicians
- Dominated by authoritarian leadership behavior
- Underserved by PAs/NPs cast into unimaginative roles

“Characteristics so ingrained in the primary care practice culture that they have become virtually invisible, along with their implications.”

Currently a non-system
  - Fragmented, poorly coordinated, and excessively costly

Collaborative delivery systems
  - An organized and collaborative provider network designed to provide coordinated and comprehensive health care services.

Care continuum
  - Personal health to palliative care
  - “Cradle to grave”
  - Health and human services
Shifting Health Care Payments

The Cost of Healthcare
We've compiled internal data from 2010 and 2011 to produce an estimate of where your Blue Shield of California health plan dollar goes.

40¢: Hospital
28¢: Physicians
12¢: Pharmaceutical
5¢: Other Medical Services
13¢: Admin Costs
2¢: Blue Shield Income

Here's how your health plan dollar is spent

85¢: Cost of Health Care
15¢: Other

Clint MacKinney, MD, MS
**Performance Improvement**

**The Value Equation**

- **Quality**
  - ACO, VBP, HEDIS, etc.
  - Common diagnoses
  - Many – so “harmonize”

- **Experience**
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- **Cost**
  - To the **payer**
Performance Reporting

- Hospital Compare
  - http://www.hospitalcompare.hhs.gov/
- Healthgrades
  - http://www.healthgrades.com
- CARECHEX
  - http://www.carechex.com/
- Consumer Reports
  - Not just hospital ratings anymore!
- Angie’s List and social media
Variation suggests a risk for underperformance, but also an opportunity to excel
Best evidence is only the way we practice medicine

Care **should** vary by unique patient needs, not by
- Doctor or nurse
- Day of week, or time of day

Not cookbook medicine, many opportunities for
- Clinical judgment
- Thoughtful interactions
- The “art” of medicine
Patient-centered medical homes are primary care practices that offer around-the-clock access to coordinated care and a team of providers that values patients' needs.

- Access and communication
- Coordination of care
- Patient and family involvement
- Clinical information systems
- Revised payment systems

Sources: Commonwealth Fund. [http://www.commonwealthfund.org/](http://www.commonwealthfund.org/)
Medical Home Quotes

- All team members practice at the top (optimum) of their license and experience
- Best evidence is the best and only way we deliver care
- Care is the same, regardless of the provider
- Continuous performance improvement of our care is rigorously driven by data
- There are no non-compliant patients, only those we have not reached
- An EHR is critical to proactively managing patient/population health
- Let care protocols do (at least some of) the work (eg, lab orders, med refills, vaccines)

Crete Physicians Clinic
Crete, Nebraska
The hospital CEO’s most important job is developing and nurturing good medical staff relationships.

Source: Personal conversation with John Sheehan, CPA, MBA
Medical Staff Development

- Physicians see themselves as independent autonomous, and in control!
- Yet, hospital-physician alignment is essential to delivering value

Some ideas
- Develop and engage physician leaders
- Provide data transparency, but do not overstate discrete measure importance
- Offer rewarding, yet reasonable salary, rather than paying piecework
- Offer direct ability to influence outcomes
- Provide a continual sense of accomplishment and recognition

Hospital Transformation

- How do we move toward value when our revenue is primarily volume-driven?
- We can test the waters
- The Process
  - Awareness – the value equation
  - Assessment – where we are right now, and where we need to go
  - Experimentation – small scale innovations
  - Implementation – new programs that drive value
- What to do right now
What To Do Now

- Control the data
  - EHR and sophisticated data analytics

- Measure and report performance
  - We attend to what we measure
  - *Attention* is the currency of leadership

- Educate Board, providers, and staff regarding performance
  - We are all “above average,” right?

- Aggressively apply for value-based demonstrations and grants

- Negotiate with third party insurers to pay for quality
More What To Do Now

- Consider self-pay and hospital employees first for care mgmt
  - Direct care to low cost areas with equal (or better) quality
  - Reduces Medicare cost dilution
- Manage care beyond the hospital
- Move organizational structure from hospital-centric to patient/community-centric
- Explore potential collaborations with physicians and others
Collaboration Questions

- How do we develop a common vision and “culture?”
- How do we respect physician identity and independence, yet promote collaboration?
- How do we define success by mission, not hospital growth?
- How do we accept that increased collaboration will require some loss of control?
Collaboration and Value

- ACOs and other “programs” less important
- Collaboration that fosters health care value is key
- Future paradigm for success
- **Good medicine and good business**
The Risk of Something New
Healthy People and Places

Clint MacKinney, MD, MS